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ABSTRACT

This paper focuses on the emergence and promise of clinical sociology. Particular attention is paid to certified practitioners' contributions (theoretical analysis, social systems perspective, levels of analysis, methodological sophistication, intervention skills and specialized body of knowledge) in health care settings.

This paper focuses on the emergence and promise of clinical sociology, one of the areas of sociological practice.[1] Particular attention is paid here to the utility of clinical sociology in health care settings.

Clinical sociology has been defined, over the years, in slightly different ways. In 1966 Alfred McClung Lee (1966:330), a past president of the American Sociological Association and a co-founder of the Sociological Practice Association, provided a fairly comprehensive definition when he identified three ways in which social scientists could be "clinical":

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(1) through critical discussions with practical observers of spontaneous social behavior in problematic situations, (2) through scientific utilization of available clinical data, and (3) through participation directly in clinical situations.

The first and third approaches are emphasized in the contemporary explanation of clinical sociology.

Clinical sociology, as defined here, involves analysis and intervention. Clinical analysis is the critical assessment of beliefs, policies and/or practices with an eye toward understanding and improving the situation. Intervention is based on continuing analysis. Intervention is the creation of new systems as well as the change of existing systems.

Clinical sociologists are humanistic scientists who are multi-disciplinary in approach. They engage in planned social change efforts by focusing on one system level (e.g., individual, interpersonal, small group, organization, community, international), but they integrate levels of focus in their work and do so from a sociological frame of reference.

The Roots of American Clinical Sociology

The origins of the field date back at least five centuries—to the work in North Africa of Arab historian and statesperson Abu Zaid Abdalrahman ibn Muhammad ibn Khaldun Wali-ad-Din al-Hadrami, best known as Ibn Kahldun (1332–1406). He founded "the science of human social organization," the basis for what is now called sociology (Baali, 1988:xi, 107). In his *Muqaddimah*, Ibn Khaldun provided numerous clinical observations based on his work experiences, which included seal bearer, secretary of state, ambassador, negotiator and judge. In the latter role, he was seen as a reformer who practiced with "strict honesty and great integrity" (Baali, 1988:1–3; Fritz, 1989a:73).

Ibn Khaldun was the first to use a scientific approach to the study of social life in combination with intervention. But he and many other individuals now designated as early sociologists, were not called sociologists during their lifetime. Identifying the earliest clinical sociologists is also difficult because many of them did not use that label for themselves. Nonetheless, a review of the work of early scientist-practitioners allows us to identify precursors and clinicians.

Among those in Europe who would be included at the very least as precursors of contemporary clinical sociology were the classical sociologists Auguste Comte, Emile Durkheim and Karl Marx.[2] Among those whose work has been identified directly as clinical sociology is Beatrice Webb (1858–1943). Webb was active in the Fabian Society and helped to establish the London School of

Economics. She identified herself with sociology and social investigation (Webb, 1938:17, 64, 67, 129, 131, 136, 175; Drake and Cole, 1948:16) and had a strong influence on British social policy (Fritz, 1989a:76).

The History of American Clinical Sociology, Part I

The early American sociologists were practitioners and professors, and some—such as Frank Blackmar (Fritz, 1990a) in Kansas and W.E.B. Du Bois (1990b) in Georgia—combined these roles. But chroniclers of the field have said that in the first third of the twentieth century, the male sociologists at the University of Chicago were the most important force in the development of American sociology. Although these sociologists had a variety of interests and perspectives, they frequently were referred to as "The Chicago School." That label was given to them as early as 1930 (Bernard, 1930:133) but apparently was not used by the Chicago sociologists of the 1920s to describe themselves (Cavan, 1983:408).

"The Chicago School" is a label with limitations. If it were replaced by one such as "The Chicago Network" (Fritz, 1985) or "The Chicago Circle" (Thomas, 1983:390),[3] the new label would call attention not only to the men in the sociology department, but to the women sociologists who held a variety of positions at the university (Deegan, 1987, 1988; Fritz, 1989a). Moreover, it would give due recognition to the involvement and impact of Chicago practitioners, including the women of Hull House, a prominent social settlement house. A label such as "The Chicago Network" also would direct researchers to look at the influence of these early sociologists on practitioners and practice settings as well as on sociology professors and university sociology programs.

The work of the early sociologists in Chicago was very much directed, in different ways, at the resolution of pressing social problems. Many of the early members of the University of Chicago's sociology department—such as Charles Henderson and Albion Small—would be included in this group along with Marion Talbot, an administrator and professor at the University of Chicago, and Jane Addams, the head of Hull House (Fritz, 1989a).

There were, of course, differences of opinion on how to get involved in the issues facing the community (Deegan, 1988:37–39). For instance, some at the university saw the settlement houses and the city as a "sociological laboratory" (White, 1929a.24–25; Park, 1929; Burgess, 1929:47)—a place where university professors might test their ideas. There was great utility to this work, but some questioned whether it might be undertaken primarily to meet the scientific interests of the professors and their students.

Others were concerned about referring to the community and settlement houses as "sociological laboratories." To them, even the use of that term seemed

to indicate a lack of respect for the work of the organizations. In their view, settlement houses, for instance, were established to meet community needs; scientific assistance could be useful but it should follow the community interests—not be the driving force for these interests.

This example illustrates the tension that so frequently exists when an individual or program tries to meet both scientific and community needs. While it is possible to meet both objectives, the struggle to do so can overwhelm the community interests or dilute the scientific possibilities. An interventionist has to be aware of the dilemma, respect the community's right to set an agenda and be accountable for proposing particular research and intervention strategies.[4]

University sociologists were very interested in working in "laboratory settings" in the mid–1920s. While some talked of doing this research in the city or neighborhood, sociologist Ernest W. Burgess (1929:47) pointed out that this work was already in progress "on a small scale. . . with institutes of child research."

Burgess (1886–1966), a graduate of the University of Chicago and a faculty member from 1919–51, is considered one of the second generation of sociologists who taught there. During his career he was president of the American Sociological Association, the National Conference of Family Relations and the Gerontology Society. Burgess was active in civic affairs in Chicago, supervised sociological work in clinics, was on the advisory board of a child guidance center (The South Side Child Guidance Center, 1930) and taught the first courses in clinical sociology.

Burgess' courses in clinical sociology were offered at the University of Chicago from 1928 through 1933 (Fritz, 1991). The courses focused on pathological cases and the analysis of personalities. They also discussed the roles sociologists, psychologists and psychiatrists held in child guidance clinics.[5]

Students enrolled in Burgess' 1928 and 1929 clinical sociology classes were the clinical sociologists at two community child guidance clinics.[6] Among their tasks (Cottrell, 1929:1):

> intensive treatment work, such as attempting treatment of the home situation, placement of the child in foster home, vocational adjustment, adjustment in school, cooperation with settlement in recreational adjustment. . .

The South Side Child Guidance Center also indicated an interest in being a "sort of training laboratory for students interested in the field of Clinical Sociology." One of the clinical sociologists, Leonard Cottrell (1929:3), indicated in his annual report that 16 students had received assistance in case analysis during the last year. He thought that full student involvement for "carefully

selected students. . . may be thought of as the clinic's most valuable function so far as the Department of Sociology is concerned."

Some of the other students in Burgess' classes were affiliated with the Institute for Juvenile Research.[7] This organization "correlated sociological investigation with the case findings of the clinics" (Stevenson and Smith, 1934:153).

The work in the child guidance clinics fit with Burgess' teaching and research interests at the time. It also went forward because the child guidance centers requested assistance and because the project received financial support. The University of Chicago's Local Community Research Committee provided grant money for this project from 1927–29. This support was matched by local funds from the Chicago Woman's Club, the South Side Child Guidance Center and the Lower North Child Guidance Center (White, 1929b:35–39).

Although the name "child guidance clinic" was not used until 1922, the idea had been put into practice as early as 1909 by William Healy,[8] the founder of the Chicago Juvenile Psychopathic Institute (Stevenson and Smith, 1934:15). In 1934 physician George Stevenson, then director of the Division on Community Clinics for the National Committee for Mental Hygiene, and Geddes Smith (1934:2) identified the functions of child guidance clinics:

> They study and treat patients; they seek to interest other community agencies in the prevention of behavior and personality disorders in children and in promising methods of dealing with them when they occur; and they attempt to reveal to the community, through the first-hand study of individual children, the unmet needs of groups of children. Some clinics also undertake the systematic analysis of case material in the hope of contributing to a more exact knowledge of child behavior, and some provide training for students. . .

Sociologists at Tulane University in Louisiana also were involved in child guidance work. Louis Wirth (1897–1952) was a full-time faculty member there and he was director of the New Orleans Child Guidance Clinic. In the spring of 1930, he was scheduled to teach what was the nation's second course in clinical sociology. Because Wirth accepted a fellowship to work in Europe that year, the course was taught by another faculty member. The course was described in the university catalog (*Tulane University Bulletins*, 1928–29) as a "clinical demonstration of behavior problems and practice in social therapy through staff conferences and field work in a child guidance center."

In 1931 when Wirth returned to the United States, he joined the faculty at the University of Chicago and published "Clinical Sociology," an article about the contributions a sociologist can make in child development clinics. The following year, he taught a course in clinical sociology.

While clinical sociology was part of the Chicago tradition from at least 1928, a discussion of the subfield first surfaced in print in New Haven. Milton C. Winternitz (1885–1959), a physician and dean of the Yale University Medical School from 1920–1935, thought of medicine as a social science. In the earliest known publication discussing clinical sociology (Winternitz, 1930), he wrote of his intention to form a "clinical sociology section." He wanted each medical student to have a chance to analyze cases based on a medical specialty as well as a specialty in clinical sociology.

Winternitz vigorously sought funding for his proposal from the Julius Rosenwald Fund through Michael M. Davis, director of the Fund's medical services. Davis had studied sociology at Columbia University[9] and been the director of the Boston Dispensary as well as the director of New York City's Committee on Dispensary Development before joining the Rosenwald Fund.

While Winternitz (1931a, 1931b) noted the success of a course in the medical school's section on public health that was "modeled directly after the outlined plan for clinical sociology," he couldn't obtain the funds needed to put the department in place (Fritz, 1989b). He never lost interest in the program, and even mentioned it in his final report as dean in 1936.

The History of American Clinical Sociology, Part II

Between World War II and the mid–1970s, sociology was publicly characterized by its empirical approaches, theoretical developments and academic employment. Periodically there was interest in applied sociology but clinical sociology essentially went unnoticed. The histories of sociology didn't include information about clinical sociology and so most sociologists thought it never existed. The development of clinical sociology also was slow during this period because clinical sociologists often were unaware of others with similar interests.

The first formal definition of clinical sociology, written by Alfred McClung Lee, appeared in H.P. Fairchild's *Dictionary of Sociology* in 1944. That same year Edward McDonagh published "An Approach to Clinical Sociology" in *Sociology and Social Research.*

McDonagh thought he independently had come up with the idea of a clinical sociology and may have been influenced by his dissertation work on the group health movement. McDonagh had noticed that "group health associations favored the centralization of physicians and medical equipment in a clinical setting and purported the advantages of pooling ideas and health providers — in opposition to solo practitioners." McDonagh's article stressed the value of working in "clinical" groups and discussed the kinds of community problems that might be tackled by a clinical research group (Fritz, 1986:11–12).

In 1946 George Edmund Haynes' "Clinical Methods in Interracial and Intercultural Relations" was published. Haynes, the first black recipient of a Ph.D. from Columbia University, was a co-founder of the National Urban League (1910) and the first black to hold a sub-cabinet post in the U.S. government. In 1946 Haynes was executive secretary of the Department of Race Relations at the Federal Council of Churches. His article discussed the department's urban clinics which dealt with interracial tension and conflict.

Publications mentioning clinical sociology now were appearing at least every few years (Fritz, 1991). Among them were ones by Alvin Gouldner (1956), Warren Dunham (1964) and Julia Mayo (1966). Gouldner also taught a course entitled "The Foundations of Clinical Sociology" at Antioch College in the mid–1950s. The course was taught at the highest undergraduate level and students were expected to have successfully completed the department's course in social pathology. The course was described in the following way in the *Antioch College Bulletin* (1953:123).

> A sociological counterpart to clinical psychology, with the group as the unit of diagnosis and therapy. Emphasis on developing skills useful in the diagnosis and therapy of group tensions. Principles of functional analysis, group dynamics, and organizational and small group analysis examined and applied to case histories. Representative research in the area assessed.

The Utility of Clinical Sociology

The Sociological Practice Association (SPA) was founded in 1978 as the Clinical Sociology Association. During the last twelve years those who established the SPA have used their collective skills in organizational development and, despite limited resources, have begun to change the landscape of American sociology. Even the most conservative sociology organizations now include information about clinical sociology in their newsletters, although these organizations still have not developed plans to integrate clinicians.

The term "clinical sociology" was first adopted in the United States by well-known university personnel who were receiving or anticipated receiving funding for clinical work.[10] Several of the first sociologists to use the term "clinical sociology" did so in a limited way—to refer only to sociological work within actual clinics. But the term was used in a variety of ways from the late 1930s to the mid–1970s.

In the 1970s and 1980s the most frequent definition of clinical sociology was a broad one. It referred to intervention on various levels (e.g., individual, group,

organization, local community, national, international) and in various settings such as clinics, courts, schools, neighborhoods and board rooms. That usage is accurate historically because some early advocates recognized the broad use of the term,[11] and a review of the variety of intervention activities undertaken by early American sociologists, such as those in The Chicago Network, shows that a broad definition has a basis in fact.

While the field can be defined narrowly or broadly, much of the actual work of clinical sociologists has been and currently is in health care settings. Clinical sociologists work, for instance, conducting alcohol and tobacco control intervention research; supervising oncology units; providing counseling and sociotherapy; consulting on the improvement of health systems and administering health delivery and funding systems.

Their major contributions in those settings differ depending on a practitioner's level of training (B.A., M.A. or Ph.D.), length and type of experience and areas of competence. Skilled practitioners have the possibility to apply for certification.[12]

In general, we might expect the following contributions from certified practitioners:

Theoretical analysis. The clinical sociologist has had extensive training in theory. The result is a working knowledge of a range of major theories in two or more disciplines that affect her or his area of specialization. The clinical sociologist is expected to:

- have the ability to translate theories for practical use
- periodically reflect on her or his own theoretical approach and the possible effects of this theoretical approach on the work undertaken
- provide theoretical perspective, when the situation warrants, for clients, colleagues, employers and interested community members.

Social systems perspective. A sociologist's training emphasizes understanding of (1) the social system—a configuration of positions, roles and norms—as a dynamic force and (2) the effects of membership in overlapping systems. Clinical sociologists are expected to be knowledgeable about systems, to move between theory and practice in working with systems and to assist individuals and groups in assessing and possibly changing systems.

Levels of analysis. The clinical sociologist is expected to concentrate on a level of analysis (e.g., individual, small group, organization, local community, international) when undertaking an intervention project.

But the translation of social theory, concepts and methods into sociological practice requires an ability not only to recognize various levels, but to move between levels for analysis and intervention (Freedman, 1984).

Methodological sophistication. A sociologist receives extensive training in research methods. Clinical sociologists are expected to know the comparative strengths and weaknesses of qualitative and quantitative methods in their practice settings. A clinical sociologist also is expected to recommend appropriate methods by taking into account the objectives of the involved parties, ethical considerations and available resources.

Intervention skills. A clinical sociologist will have interdisciplinary training and substantial intervention experience in her or his specialty area. The certified practitioner would get beyond simply pointing out a few of the difficulties in a situation. The practitioner would provide analysis,[13] suggest alternative ways of dealing with a situation and, when possible, actually initiate or assist in the intervention. In any intervention, the clinical sociologist is bound by a code of ethics and is expected to identify and address ethical issues that may arise.

Specialized body of knowledge. Each clinical sociologist has a frame of reference which emphasizes social factors (e.g., socio-economic conditions, ethnicity, gender) and at least one or two areas of special competence — e.g., health promotion, gerontology, counseling, community organization or social policy. A clinical sociologist is expected to work in areas where she or he has particular expertise, and to advise interested parties before undertaking work that goes beyond the special areas of knowledge or intervention.

The six contributions mentioned here are general ones. The list would be longer if one takes into account an individual practitioner's skills and the requirements of the task at hand. Clients, colleagues and employers also should understand that clinical sociologists are not the only ones with these skills. Practitioners in various fields may be sensitive to these areas, although a certified clinical sociologist's training may have broader emphasis on theory, research methods and systems analysis than some other fields.

Clinical sociologists have made valuable contributions in health care settings for over sixty years. If this trend is to continue, sociological practitioners must take advantage of the ongoing networking possibilities and have more training and employment opportunities.[14] At the same time there must be growing

recognition of the contributions of clinical sociologists and better collaboration among the disciplines involved in health care.[15]

Notes

[1]The practical sociology of the 1890s and early 1900s is now referred to as sociological practice (Fritz and Clark, 1989). This label includes two areas, clinical sociology and applied sociology. Clinical sociology refers primarily to intervention while applied sociology refers to research specifically designed to help in resolving problems faced by organizations such as businesses or government agencies.

[2]Comte believed the scientific study of societies would provide the basis for social action. Durkheim and Marx provided a clinical perspective — a model or framework — for the analysis of social dilemmas (Fritz, 1989a:73).

[3]Deegan (1988:3) plans to write a volume which will describe the " 'female' Chicago School of Sociology." The alternative names — Chicago Network or Chicago Circle — would more adequately cover the practice and academic bases from which the women operated.

[4]Stoecker and Beckwith (1990:4,8–9) have the following to say about the relationship between community projects and applied sociology: "The general 'top-down' bias of applied sociology is reflected in Freeman et al.'s (1983) *Applied Sociology*, which discusses numerous applied projects, none of which have been generated, developed and controlled at the grass roots level. . . Nowhere in the development of applied sociology as we know it was adequate attention given to the influence of power and ideology on applied sociological research. Applied sociology has merely responded to elite generated definitions of problems, and serves only those who can pick up the tab. Even those who believe they are taking account of the needs for citizen participation and democracy innocently reveal their lack of real attention to power issues. . . In contrast to 'applied sociology,' . . . action research is based in community-defined needs rather than elite-defined needs, involves community members in the research process rather than isolates them from it, and employs the research results for the benefit of community action rather than elite domination."

Stoecher and Beckwith make some excellent points but their target shouldn't be all applied sociology. Applied sociology certainly includes "elite-dominated" research but it also includes action research projects.

[5]Louis Wirth was director of the Child Behavior Clinic at Tulane University (Smith and White, 1929:265) and *Tulane Scraps*, 1929) and Harvey Zorbaugh was in charge of a clinic at New York University. They held academic appointments in sociology and educational sociology at their respective universities and, at some point, provided research assistance to the University of Chicago's Local Community Research Committee (Smith and White, 1929:258–65).

[6]Clarence E. Glick (1989) began graduate study at the University of Chicago in the spring of 1927. Burgess arranged for Glick to be the clinical sociologist at the Lower North Side Child Guidance Center. Another class member, Leonard S. Cottrell (1899–1985), was for two years a "Clinical Sociologist for the Institute of Juvenile Research" and acted as such with the South Side Child Guidance Clinic. Cottrell also was a probation officer for the Juvenile Court for two years and a research sociologist for the Institute for Juvenile Research for one year (Cornell University Archives File on Leonard S. Cottrell, biographical statement for promotion, n.d.).

[7]According to a document in the Burgess Collection at the University of Chicago (Laboratory for Criminological Research, n.d.),

> [The Institute for Justice] is the oldest center for child study in the United States having been founded in 1909 under the name The Juvenile Psychopathic Institute, with Dr. William Healy as director. Under the administration of Dr. Hermann M. Adler, 1917–29, it was transferred from county to state auspices and has expanded its work in many directions . . . In Chicago it maintains a branch at the Juvenile Detention Home and has affiliated with it the Lower North Side Child Guidance Center and the South Side Child Guidance Center. Besides maintaining a service program, it conducts a large research program. The case records of children examined is now increasing at the rate of 1,000 a year.

[8]According to Ruth Shonle Cavan (1983:413), a graduate student at the University of Chicago from 1922 through 1926, "In his course on delinquency, Burgess depended on a series of cases of delinquent boys published by a psychiatrist, William Healy."

[9]Davis wrote his dissertation, *Gabriel Tarde, An Essay in Sociological Theory*, in 1906.

[10]Winternitz vigorously sought funding for a department of clinical sociology from the Rosenwald Fund (Fritz, 1989b), and Burgess' work in clinical sociology had funding from a university research group, a local women's organization and child guidance groups. Tulane University sought funding for its child guidance center from the Commonwealth Fund and the Community Chest (*Tulane Scraps*, 1929; Wyckoff, 1925, 1928).

[11]For example, Dean Milton Winternitz (1932:50–51) of the Yale Medical School said the following in his 1930–31 annual report to the president of Yale:

> The field of clinical sociology does not seem by any means to be confined to medicine. Within the year it has become more and more evident that a similar development may well be the means of bringing about aid so sorely needed to change the basis of court action in relation to crime . . .
>
> Not only in medicine and in law, but probably in many other fields of activity, the broad preparation of the clinical sociologist is essential . . .

[12]The Sociological Practice Association (SPA) has certified experienced clinical sociologists since 1984. To gain the title "certified clinical sociologist," an individual must submit an acceptable portfolio which includes documentation about training and experience. The applicant must have had training in sociology and in a related discipline, written theoretical and ethical statements and provided specified kinds of references. If the certification committee finds the applicant's portfolio acceptable, the applicant is invited to give a demonstration before peers and a reviewing panel. The applicant takes part in a discussion with the audience and then meets privately with the reviewing panel. The reviewing panel rates the applicant and makes a recommendation regarding certification to the SPA Certification Committee.

[13]Roger Straus (1984:52,54) has said that sociological intervention may be characterized in the following way:

> (1) directed at the operational definition of the situation, in such a way as to (2) take into account the multiple, interacting layers of social participation framing human problems and predicaments and their resolution.

Straus also provides the following taxonomy of sociological intervention:

Level of Participation	*Target of Intervention*
Persons	Conduct
Groups	Role Structure
Organizations	Institutions
Worlds	Culture

[14]Some initiatives — such as state licensure, job classification and third-party payment authority—may set standards for health care, but they also may be exclusionary. Because of the costs involved in tackling current and proposed restrictive policies, professional organizations that are relatively small and have few resources are not able to assure members that they can protect their right to practice.

[15]"Collaboration" should mean that each of the disciplines involved in health care has the possibility of taking the lead in situations requiring research, administration and/or intervention. Too often one field may dominate and this limitation may mean that certain problems are not considered and certain theories or methods are not used.

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